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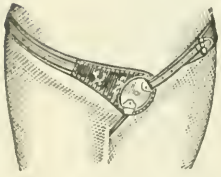

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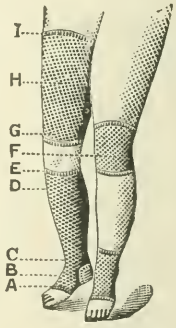

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INTRA-ARTICULAR FRACTURE FIXATION, WITH REPORT OF TWO CASES.

By Nathan Winslow, A.M., M.D.,
Clinical Professor of Surgery in the University of Maryland

The advisability as well as practicability of internal splintage in extra-articular fracture with bad position has been so definitely proven that it is needless to further dilate upon the subject. It is common knowledge. With intra-articular fracture, however, a different problem confronts us. Invariably the teaching has been that no foreign substance should be inserted—with the idea of permanency—in a joint. Sherman and Tait (*Surgery, Gynecology and Obstetrics*, August, 1914) have done some experimental work in intra-articular pegging in the dog and cat, and depict the results obtained with radiographs. They claim from an experimental point of view this procedure is perfectly warrantable in man. In June, 1913, a case of fracture through the head and anatomical neck of the humerus came into the service of Professor Randolph Winslow at the University Hospital, Baltimore, Md. As he was out of the city at the time, the patient fell into my hands. Suffice it at this time to say, finding it impossible to retain the fragments in apposition, a wire nail was driven directly through the articular surface into the shaft of the bone. Only recently, under like circumstances, a colored child with separation of the lower epiphysis of the humerus also came into my hands. Here a like procedure was pursued, save two very small wire nails were employed. In both instances, after incision and reposition it was found impossible to retain the fragments in apposition, and as the non-articular surface presenting in either instance was so slight that no space afforded a sufficient hold for a nail, the lesser evil to my mind was chosen, and nails driven directly through the articular surface of the bone rather than the obtainal of bad union with consequent faulty function, bearing in mind the ultimate removal of the nails if trouble arose.

In cases where fracture so upsets the joint surface that motion will be interfered with, or where reposition by other methods is inefficient, one must turn to the possibility of intra-articular splintage. The question naturally arises, Are screws, plates or

nails tolerated within a joint? Sherman and Tait have answered this question experimentally, and we believe we have done so practically. Our work was done absolutely independently of Sherman and Tait's, and was the result of the force of circumstances. In both instances the work was done before we had seen the article of the above-mentioned gentlemen. According to Tait and Sherman, in 1890 Charles Phelps of New York reported a series of cases of fractures of the patella treated by longitudinal ligation with silver wire. On the articular surface the wire was buried in a groove cut in the cartilage for its reception. Phelps stated, without clinical or post-mortem proof, that

Figure 1.—Before attempt at reduction. Lateral view.

the wire would be covered in and cause no subsequent trouble. These writers also state that a careful search of the literature fails to reveal other instances of intra-articular fixation appliances. Amongst others, from their experimental researches they arrive at the following interesting and instructive conclusions:

Screws and plates so used seem to be *per se* innocuous. Aside from the trauma incidental to their insertion, the reaction following the introduction of screws and plates does not differ from that caused by a foreign body in other connective tissues of the body. When properly countersunk they are rapidly excluded from the joint cavity by a layer of newly-formed fibrous tissue which grows up from the marrow spaces. Under aseptic conditions the ultimate fate of intra-articular metallic fixation appliances is

the same as that of extra-articular appliances. They remain firmly embedded. Even with slightly projecting intra-articular screws or plates, the function of the joint rapidly becomes normal. The direct wearing away of cartilage by an insufficiently countersunk screw-head does not lead to intra- or extra-articular deformities, except under faulty technical conditions.

Though they have never had occasion or opportunity to apply

Figure 2.—Before attempt at reduction. Antero-posterior view.

a screw or plate in man, they believe that even in the presence of trauma the replacement and maintenance of the replaced fragments or epiphyses by screws will give better results than by permitting the persistence of displacement with its consequent disability. They believe that the method of extending to intra-articular fracture the internal fixation apparatus used commonly in extra-articular fracture will, in properly selected cases, give the injured a more useful joint than the pursuance of the methods now in vogue. We believe that our work on man, which was

done without knowledge of the experimental work of Sherman and Tait, conclusively proves their contentions.

REPORT OF CASES.

P. M., aged 50, white, a native of Poland, but now a resident of Baltimore, tailor by trade and single, entered the University Hospital May 28, 1913. There was nothing in the family or previous history or physical examination of interest, save that the patient was suffering with a fracture at the upper end of the

Figure 3.—Same as Figure 1. After attempt at reduction.

humerus. As he could speak but little English, it was utterly impossible to obtain much of a history except that the patient had fallen and injured his shoulder. After admittance to the hospital his arm was temporarily immobilized so as to permit swelling to subside. Later an attempt was made at reduction and the injured member put at rest in the Albee position. In order to ascertain the position and the extent of the fracture a skiagraph was made on June 19, 1913. The findings revealed a fracture through the head and the anatomical neck with bad position. As nothing

could be expected from external manipulation, on June 28, 1913, the patient was brought to operation, ether being the anesthetic. An incision was made midway between the acromion and coracoid process and extending about seven inches down the arm. The distal fragment was delivered through the incision. Then the head of the bone was sought out, separated from its capsule, and entirely delivered from the body. The fragments were next brought into apposition, but the upper fragment was so shattered

Figure 4.—Same as Figure 2. After attempt at reduction.

that it offered but little surface for plating. After some difficulty a very small plate was insecurely attached to the fragments, but it was immediately seen that the plating would prove ineffectual unless reinforced in some other way. No other surface presenting, a wire nail was passed through the articular surface into the shaft of the bone, the capsule sutured, the remaining wound closed and the arm encased in plaster. As the temperature of the patient was somewhat elevated and he complained of pain, the dressings were removed at the end of a week and the wound inspected. As there were indications of inflammation the silkworm gut sutures

were removed, when pus escaped. The temperature continued after this for some days to vary between 100 and 102 degrees F., pulse 110 and 120, respirations 20 and 24, but by the time of discharge from the hospital all had become normal. This inflammation finally resulted in sinus formation, the sinuses leading to the head of the bone. Gradually the sinuses, with the exception of one which discharged a straw-colored fluid, closed. In this condition the patient was discharged September 29, 1913, and directed to go to the dispensary for future dressings. On January

Figure 5.—Fragments reduced. Held in place by nails inserted intra-articularly.

12, 1914, the patient, as the sinus had failed to close, returned to the hospital. On January 14 Professor Randolph Winslow opened the previous incision to the bone and removed a plate with three screws. He then opened the capsule and disarticulated the head, but a careful search failed to reveal the head of the nail, so the sinus in the bone was enlarged and the nail grasped at its point by a pair of forceps and pulled out in a retrograde manner. The sinus was curetted and drained, the skin wound lightly closed.

The re-entrance note stated: The patient had no crepitus in the arm and good motion in all directions, save elevation. By the ninth day the sinus had closed. The patient was discharged January 30, 1914.

V. T.—This patient, colored, aged 3, is too young to give any history of the manner of receipt of injury, so we are unable to give a detailed history of the case, save to say that she entered the hospital August 3, 1914, and was subjected to a radiographic examination, which revealed a separation of the lower humeral epiphysis. On August 7, 1914, an attempt was made at reduction by hyperextension and flexion with the patient under ether

Figure 6.—End of nail projecting into shaft of bone from articular surface.

anesthesia, but, according to a second radiograph, with indifferent success. So on August 9, 1914, the patient was again anesthetized and an incision made over the olecranon process down to the bone, the fragments delivered after a great deal of trouble. As no surface presented extra-articularly through which nails could be passed, and the fragments not remaining in apposition when released, two small wire nails were passed from the articular surface through the epiphysis into the shaft. September 1, 1914, the patient is still in the hospital, but carrying her arm free of any immobilizing apparatus, this having been removed on the tenth day after the operation. At present there is some motion in the joint. According to the X-ray the nails were not sufficiently sunk, but we believe that the projection is not as great as the skiagraph

would lead one to believe. The highest temperature after operation recorded was 101.2 F., pulse 110, respiration 24.

It is as yet too early to prognosticate the ultimate functioning power of the elbow, but one can rest assured without operation function would have been materially interfered with.

We believe this work conclusively proves that intra-articular fractures which cannot be handled otherwise should be screwed or pegged from the articular surface; that the human joint tolerates a foreign body provided infection does not occur; that this method offers more prospect of a useful member than by leaving the fragments in bad alignment.

ROUND LIGAMENT SUSPENSION OF THE UTERUS—FIFTY-FIVE CASES.

By William Sisson Gardner, M.D.,

Professor of Gynecology, College of Physicians and Surgeons, Baltimore; Gynecologist to Mercy Hospital.

THIS paper is based upon the reports from 55 cases of retrodisplacement of the uterus that have been treated by round ligament suspension. A part of these suspensions were done after the method described by Gilliam, the remainder by bringing the round ligaments up through or near the inguinal canal. In all instances the round ligaments after being drawn up were attached to the fascia over the recti muscles. The cases that had other lesions that predominated over the retrodisplacement were omitted. The other lesions treated in connection with the correction of the displacement are noted.

The records were written by hospital internes, and are necessarily more or less incomplete, and no doubt more careful inquiry would have made some difference in the recorded symptoms, but they are sufficiently correct to give the important points in about their relative proportion.

The case of the longest standing was operated upon 12 years ago; the most recent one over one year ago. No cases have been included that have not been personally examined or been heard from within the past few months.

Of these patients, 42 had had one or more children; 13 were nullipara. In an estimation on a large number of cases made several years ago it was found that 25 per cent. of retrodisplacements occurred in women who had not borne children. In the present series very nearly the same proportion is preserved.

Thirty-six patients complained of pain at the menstrual period. In 17 of the 36 cases the pain was an increase of their general backache and pelvic pain that they suffered from more or less between periods. In the other 19 cases the pain was of a different character. It was a sharp, severe pain, beginning from one day to one

week before the flow, usually continuing throughout the flow, and in a few instances recurring after the flow.

Twenty-one patients had severe occipital headache just before or during the menstrual period.

There was an increase in the loss of blood at the menstrual period in 19 patients. This increase is commonly a prolongation of the period and a relatively small daily increase in quantity, the total amount of blood lost during the menstrual period being considerably more than normal, but no profuse hemorrhage. In 18 cases the menses were irregular. In a few instances the periods came farther apart than normal, but in most instances the periods were less than 28 days apart.

Thirty-seven patients had backache and 30 had pain in the pelvis. Only one patient complained of severe intermenstrual pain.

Twenty-two of these patients were markedly constipated. It is well known that in a small percentage of retrodisplacements, the enlarged displaced uterus causes mechanical constipation by pressure upon the rectum. No doubt the vast majority of cases of constipation associated with retrodisplacements have no direct relation to the retrodisplacement.

The records show that 15 of these patients complained of poor appetites. One of them was nauseated when on her feet. Another one became nauseated at each menstrual period. The patient who became nauseated when on her feet had both ovaries prolapsed.

Micturition was frequent in 16 of these patients, and the pain with micturition occurred only five times. The frequent micturition in most cases of retrodisplacement is due to the pressure of the base of the bladder against the symphisis by the cervix. This symptom disappears promptly when the pressure is relieved.

As was stated in the earlier part of this paper, only those cases are included in this list in which retrodisplacement was considered the predominant lesion, but in addition to suspension, the following supplementary operations were performed:

Laceration of the cervix, repaired, 3 cases; laceration of the perineum, repaired, 17 cases. The uterus was dilated and curetted 20 times. In 15 cases, one or both ovaries were suspended. In 4 cases, one ovary was removed. Both tubes were removed in one case. The appendix was removed in 12 cases. There was one case of ventral hernia, and one relaxed anterior vaginal wall repaired.

Of these patients, 41 were entirely relieved. In six of the cases the uterus remained in position, but the symptoms were not relieved. In six cases there were marked improvement, but not entire relief. In two patients the symptoms were not improved, but it is not known whether the uterus remained in position or not. In not a single instance where the patient has been examined again has the uterus been found out of position.

The six patients who have been examined and the uterus was

found in good position, but the patients were still having trouble, form an interesting group and deserve more than passing attention.

Patient No. 2267 was a small, badly-nourished, overworked neurotic woman. She had a retrodisplacement, but was advised at the time that the correction of the displacement was only an incident in her treatment, and that what she needed was a thorough rest cure. As soon as she could get on her feet after the operation she left the hospital. Since then she has not followed the course advised and has never become strong.

Patient No. 1882 returned a little over a year after her suspension, and stated that she was menstruating every two and a half to three weeks. The flow was scanty, but very painful. The pain continued about one week. Between periods there was a great amount of pelvic pain. She also complained of trouble with her rectum, vagina, and a pain in the left side. Physical examination showed the uterus to be in a normal position, but it was tender on pressure. A course of local and general treatment extending over a period of two months gave no relief. At the end of that time a supra-vaginal hysterectomy was done, since which time she has been quite comfortable.

In 1905, patient No. 593 had her perineum repaired, both ovaries suspended and the round ligaments shortened. In 1906 she had recurrent attacks of very severe pelvic pain. The left ovary was found to have become very much enlarged, and was removed. Pains having recurred again in 1909, a supravaginal hysterectomy was done, since which time the patient has been comfortable. At this operation the uterus was found to be in a good position, slightly enlarged, but there were no adhesions and nothing was found to account for the very severe attacks of pains from which she had suffered.

Patients No. 2082, No. 1820 and No. 1727 all have the uterus retained in good position, but their complaints have not been materially relieved.

Whenever the diagnosis of retrodisplacement of the uterus is made, the question as to the method of its treatment follows immediately. While it is true that an occasional retrodisplacement is seen that gives rise to few, if any, symptoms, the great majority of them cause so much discomfort that the patients must be given relief.

Many of them can be relieved temporarily and a few of them permanently by the use of a pessary. The pessary is the most useful in cases of acquired retrodisplacements where the pelvic floor is intact and the treatment is begun soon after the displacement has occurred. In acquired retrodisplacements of long standing and in congenital retrodisplacements the pessary is of very little value. An occasional case in either of these groups may derive some benefit, but in the vast majority of them the pessary is useless. It, of course, follows that in cases where the pelvic diaphragm is defective, either from injury or from failure in development, that the pessary cannot be used to advantage. In a consider-

able percentage of cases in which the pessary apparently gives relief, this relief is only temporary, because the relaxation of the vaginal outlet has a tendency to increase with age, so the support that the pessary must have becomes more defective, until such a time arrives that the pessary can no longer be retained.

In my experience the pessary is almost useless in retrodisplacements in nullipara. In a few of them the uterus can be kept in position, but the symptoms do not disappear. This condition is well illustrated by No. 1070. She was a young married woman who came to me on account of sterility and an exceptionally severe dysmenorrhea. For five months I endeavored to relieve her without resorting to an operation. The uterus could be kept in position, but the dysmenorrhea grew worse. In March, 1911, one ovary was resected and both ovaries were suspended and the round ligaments of the uterus shortened. Her dysmenorrhea was entirely relieved, and within a year she became pregnant.

In all these cases which cannot be relieved by the pessary it is necessary to resort to some operative procedure.

Many operations to replace the uterus and secure it in the correct position have been devised. The operation of ventral suspension, which was introduced in this country by Dr. Kelly, was very popular for a number of years, and a very large number of them were done by many operators. The frequent failure to retain the uterus in position, the occurrence of the ventral fixation in place of the intended suspension, and the complications during pregnancy and labor in patients upon whom this operation had been done have caused it to be abandoned by nearly all surgeons.

Among the various round ligament suspension operations that are most widely done are the Baldy-Webster operation and the Gilliam operation or some modification of the latter. Polak reports that out of 376 cases operated upon by the Baldy-Webster method, in 32 cases the uterus has relapsed and was found retroverted and prolapsed, carrying the ovaries with it. Ten have lateral version of the uterus and complain of pain in the side toward which the fundus is turned. Sixteen have prolapsed cystic ovaries. Twenty-six have had thrombosis of the pelvic veins, which has extended to the femoral and saphenous, which gives a morbidity larger than he has had from any other intra-abdominal operation.

In conclusion, Polak states that the Baldy-Webster operation has a definite field of usefulness in properly-selected cases of retrodeviation of the uterus when intra-abdominal shortening of the round ligaments is employed. It should not be selected for heavy uteri with the cervix in the axis of the vagina. Its success depends on a small uterus, a cervix pointing backward, equally developed ligaments and a careful technic.

In the Gilliam operation the abdomen is opened by a short median incision just above the pubis. The fat and skin are dissected off the sheaths of the recti muscles on both sides. A small opening is then made directly through the rectus muscle on each side of the abdominal incision, and a loop of the corresponding

round ligament is drawn up through this opening and stitched to the fascia of the rectus. The shortening of the round ligaments by this method pulls the fundus of the uterus upward and forward. It has the defect of leaving artificial pillars extending from the uterus to the abdominal wall, and the traction on the uterus is not in the normal line of the round ligaments.

A slight modification of this operation obviates both of these objections. If the lateral dissection is carried beyond the outer border of the rectus muscle a curved mouth-toothed forceps can be inserted through the inguinal canal and carried down beneath the peritoneum to a point near that portion of the round ligament that is to be brought up. The forceps are then made to puncture the peritoneum and the round ligament is grasped about one and a half inches from the uterus and the forceps is withdrawn, bringing with it a loop of the ligament, which is stitched to the fascia in such a way as to firmly fix the round ligament in this position and to close the opening made in the fascia by the forceps. The same procedure is carried out on the other side.

By this method the traction on the uterus by the round ligaments is very much more nearly in the normal line of the round ligaments and no artificial pillars are left in the abdominal cavity. There is no interference with the circulation in the broad ligaments, and there are no intra-abdominal stitches or other traumatisms to favor the formation of adhesions.

No. 6 W. Preston Street.

The Clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. August, 1914. Published Bi-Monthly. Philadelphia and London: W. P. Saunders Company. Baltimore: The Medical Standard Book Co. Paper, $8 per year.

Everybody is now familiar with Murphy's Clinics, or at any rate should be. It is therefore needless for us to enter into long encomiums. Suffice it to say, each issue has so far proved its usefulness as well as helpfulness. The present number should be no exception. Here, as heretofore, surgery of the bone enters largely into the makeup. Yet one cannot too often be impressed with what can be done for those individuals suffering with ankylosed joints and ununited fractures. Constant repetition drives the lesson home, and one is less likely to forget when confronted with those conditions if he is thoroughly conversant with Murphy's methods. Do not get the idea, however, that there is nothing else in the volume, for such is not the case, as there are instructive articles on intrauterine fibroids with hysterectomy, cerebellar tumor with decompression, malignant papillomatous cyst of the breast, differential diagnosis and operation.

SOME REMARKS, WITH ILLUSTRATIVE CASES, CONCERNING THE PATHOGENESIS OF CERTAIN NEURALGIAS IN RELATION TO INFLAMMATION, TOXICOSIS AND NEUROSIS.

By Tom A. Williams, M.B., C.M., Edin., Washington, D. C.
Prest. Wash. Soc. Neu. and Ment. Dis.; Corres. Mem. Soc. de Neurol., Paris, etc.

A WOMAN of 57 was referred by Dr. Thomas Charles Martin in June, 1914, on account of intermittent neuralgia of the right side of her face. The pain began in the right lip, eye and temple, later extending to the ramus. It was aggravated by damp. She is a woman of nervous temperament, and sleeps poorly, and has had renal and bilary cholic for 30 years until relieved by operation nearly three years before.

In 1912 she had an attack of right upper thoracic zona without sequelae. Six months ago she had acute laryngitis while in Boston, and a pharyngitis later while in Philadelphia, to which she is subject when there. For two years the right lower third molar has been treated by her Boston dentist. Recently a return of hepatic colic has required modification of her diet at the hands of her physicians in Philadelphia, who have forbidden fried and red meat, strawberries, eggplant, rhubarb, etc., but who have not interfered with a somewhat excessive consumption of protein. However, she showed no signs of faulty metabolism, and her blood pressure was 124, the diastolic being 84, with a small soft artery.

The reflexes were of the active kind.

The sensibility was normal, save for a hyperesthesia to vibration and pin over the right face and neck.

The muscles were firm.

Diagnosis.—On account of the hyperesthesia and its location, I expressed the opinion that this was a neuralgia of dental origin; but the patient was reluctant to believe this, as her Boston dentist had assured her that her condition could not proceed from the teeth. However, she consented to see Dr. Anderson in Washington.

He at once found an abscess at the root of the third molar. To this he attended, and within three weeks the neuralgia disappeared.

At the same time, the protein of the patient's diet was diminished, and she was given advice to protect her from well meaning friends and relatives who always were tormenting her with advice to rest because of their fear of a breakdown, due to their misunderstanding of the nature of her nervousness, which was merely a manner of reaction of an intensely energetic temperament in a woman of unusual balance and capacity.

CASE II.—A woman of 40 complained of an intense neuralgia in the gum whenever hot or cold food came in contact with it. The

pain following this was sometimes so intense as to incapacitate her, and as she was a valuable employe, her employer wished her to be cured if possible. Her health had been otherwise good, but she was excessively stout, and her blood pressure had been 160. There were no abnormal physical signs, except at the site of the neuralgic gum, where a tenderness was revealed by pressing a scar tissue where the teeth had been removed.

Diagnosis.—This led me to the opinion that an inflammatory condition of the nerve endings in the scar tissue was responsible for the neuralgia, and I sent the patient to Dr. Anderson, who completely relieved her by building a protective ridge over the bare gum.

At the same time, the condition which led to the hypertension and adiposity was met by an appropriate dietary and exercises, which within a month reduced the blood pressure below 140.

The advisability of the latter treatment is on account of the belief that the toxic condition induced by hyperproteosis greatly aggravates the local irritation of peripheral nerves by inflammation or trauma. Everyone who has experienced a chronic abscess at the root of a tooth knows how the pain varies in correspondence with his general condition. The influence of the atmosphere is believed to be exerted in this way by altering heat radiation and conduction, and by interfering with the carbon dioxide diffusion in respiration, thereby modifying the metabolism. Where trauma is concerned the confessions of the bearers of amputation stumps and sufferers from ligmentous strain tell the same story. Whether the pain is due to a species of histological gout, an actual deposition of irritating materials in the tissues, or whether it is caused by a contraction of the arterioles altering the osmotic condition of the part is problematical. But that the pains occur and that they are relieved by such tissue stimuli as massage and alterations of temperature induced by water or electricity is highly significant.

I am not here considering the remote aponeurotic, arthritic and neuritic pains caused by the diffusion of a septic toxin absorbed from a circumscribed focus elsewhere; for exogenous toxins are not in question in the chronic neuralgias which we are discussing now.

Whether toxic absorption played any part in the case which follows seems also doubtful to me. It seems to belong to the class of cases once thought very common, but now believed quite unusual, where the persistent irritation of a peripheral nerve leads to the diffusion of its stimulus to remote portions of the nervous system with the causation of clinical syndromes labeled neurotic.

AN "OCCUPATIONAL NEUROSIS" CAUSED BY TOOTHACHE.

A married man in the Federal Forest Service had for some years done much office work, entailing the responsible control of other men. He was brought to me because he had suddenly begun to vacillate concerning administrative decisions. From his wife and

children finding it necessary to remain in the West while he was in Washington, he denied any disturbance. But the fact remained that he contemplated going to them on a long vacation, as his work was more than he could stand. For a few days he had developed a severe neuralgia, paroxysmal in nature, but not due to faulty teeth according to a dentist. Examination was negative, and I attributed his condition to the metabolic disturbance caused by prolonged stress, worry and unhabitual sedentariness. I advised a trial of low nitrogen diet, active exercise and freedom from work for a few days. However, the pain became so acute that the patient insisted upon extraction of the most painful tooth. Forthwith all his unpleasant symptoms disappeared. The patient declared that he felt as if a huge incubus had suddenly been removed. He immediately returned to work without further trouble.

This was clearly a case of peripheral nagging, preventing the harmonious integration of the nervous system needed for psychological adaptation. It had etiologically nothing to do with occupation as such.

CONCERNING "REFLEX IRRITATION" AND NEUROSES.

At one time tremendous emphasis was laid upon the irritation of the nerve terminals as a source of neurasthenia, hysteria and neuroticism in general. Innumerable turbinates have been shaved, appendages removed and errors of refraction corrected on account of this notion. But extended experience has convinced even the most ardent specialist in rhinology, gynecology and ophthalmology, when they are possessed of scientific honesty and clear-mindedness, that comparatively few neurotic cases arise from purely reflex irritation.

There is still, however, much confusion as to the genesis of the psychoneuroses. The source of this confusion lies in the want of clear differentiation between symptoms referable to the autonomic nerves and those which often so closely resemble them, although originating psychically. A few examples will make this clear.

The abnormal frequency of micturition in the earlier period of gestation has its source, in all probability, in the stimulation of the afferent nerves from the neck of the bladder on account of the stretching of the tissues around the utervesical pouch by the rapidly expanding uterus. Any impulse passing by this tract is necessarily interpreted as an irritation of the mucous membrane by urine, which experience has taught us to associate with need for micturition. There is really an illusion, comparable to that in one's toes when the nerves are stimulated in the stump of an amputated leg or in the more familiar "funny bone" experience or in referred pain.

Now the sensations derived from these are totally unamenable to psychic influences, although, of course, the patient's response to the sensations is modifiable by the will.

Very different is the case of the nocturnal incontinence of chil-

dren, perhaps one of the most typical of the misunderstandings of the theorem now being illustrated. This affection is purely psychogenetic; for it is due to a failure to educate the cortical inhibition so that it may maintain itself during the relaxation of sleep.

In connection with this, there is another common misapprehension that during sleep consciousness is suspended. That is not the case, as innumerable examples prove. Only two of these need be cited. One is the power which many people possess of appreciating the lapse of time while they are asleep. They can approximately judge the hour when they awake accidentally during the night, and can determine in advance the hour at which they should wake in the morning. Another series of facts shows that we are not even insensible to peripheral stimulation during sleep. For instance, by stimulation of the skin, muscles or special senses the contents of dreams can be determined; not only that, but direct ideas can be inculcated in speech, and a psychotherapeutic method has been based upon this fact, especially in childhood; indeed, it has been particularly applied to incontinence of urine, on account of the supposed efficacy of what its exponents are pleased to call the "subconscious." We need invoke no such hypothesis; for suggestion during sleep, hypnosis or any other "passive" state is more effective merely because the idea invoked then dominates the field of consciousness uninterrupted by other extraneous stimulations; hence it is more easy to gain the attention and make an idea penetrate in these states; but the technical skill which we call persuasive power is capable of doing the same with the subject in no matter what state. The problem is merely one of fixing an idea in the patient's mind, so that it may energise toward the desired end. The art of doing so is psychotherapy; but it is only proper and is most successful when based upon clear diagnosis. This is only possible after a study of the patient by the methods of clinical neurology, which enable us to comprehend the psychogenesis of the disorder by unraveling its mechanism.

1705 N Street N. W.

THE PASTEURIZATION OF MILK.

By Asa B. Gardiner.

The man who sells milk has been very much interested in the attitude of the medical profession toward milk pasteurization. The modern milkman is fully posted on all details of milk. Nearly every large dairyman has his own laboratory; the management is fully posted as to the medical side of the milk question as it is of the legal and the business side. Its library collects all information and they will usually be found to be up to the times.

Low-temperature pasteurization of milk, that is, 145 degrees for 30 minutes, is one of the most successful food safeguards that

has been discovered in the last 20 years, and milk pasteurization today would not be as general and its results would not be as beneficial to the general public if the milkman had not continued his fight for pasteurization in the face of the medical profession who talked ricketts and all kinds of other trouble, in the face of boards of health, who claimed that pasteurization was a cloak only for bad milk, and even today the true facts regarding milk pasteurization seem to be little known or understood among the medical fraternity at large.

First, the distinction between pasteurization and sterilization does not seem to be understood.

As accepted in this country, 185 degrees for three minutes is a high limit of pasteurization and has been discarded because at 175 degrees the salts are affected, at 167 degrees the taste is that of scorched milk, at 165 degrees the albumen is changed and the enzymes are also changed, and at 155 degrees its cream line is wiped out and the cream no longer rises. All these things go to show that at this heat the chemical composition, the taste and the digestibility of the milk is affected. At 145 degrees for 30 minutes not one of these bad effects are noticed, nor is any other, and the digestibility remains the same as with raw milk, but at this temperature and for this time (and this has been demonstrated time and time again without question) all the pathogenic germs have been killed. Typhoid, diphtheria, streptococci, tuberculosis and colon baccillus have all been destroyed. On the other hand, many of the beneficial lactic acid germs survive this time and temperature, and, following pasteurization, lack of care of the milk and age is shown by the milk souring, a safe result rather than the danger of putrefaction.

Sterilization of milk, that is a temperature of 212 degrees for two or more minutes, is evidently worse in its effects than the temperature of 185 degrees.

Today the proper pasteurization of milk and the need for it has been recognized by the cities of New York, Boston, Chicago, Philadelphia and St. Louis, and the improvement in the health of the children and in the general health of the people has been distinctly shown as a result of such ordinances.

PYLOROSPASM IN AN INFANT.

By Wm. T. Watson, M.D.

Baby M——— weighed 9 pounds at birth. Was fed at the breast with the exception of one or two feedings daily. Throve well up to the end of the second week, when it vomited the breast milk after nearly every feeding. I saw it when three weeks old and after vomiting had continued one week. It then weighed the same as at birth—9 pounds. The food came up with considerable force but with no apparent discomfort to the infant. Small dome-

shaped waves of peristalsis could be seen emerging from the left costal margin and passing to the right of the median line. Before one wave had faded out another was on the way. On the first day I saw it only two of eight feedings were vomited. The next day only three feedings were retained. The majority of feedings continued to come up. At four weeks the weight was 8 pounds; at five weeks, 7 pounds, where it remained for a little over two weeks, and then slowly began to rise. When three months old it had reached its weight at birth, viz., 9 pounds. At eight months of age it was strong and well, weighing 18 pounds.

As the baby got thinner the peristalsis became more evident and could be seen several feet away. The pylorus was not palpable. At no time was the baby cross or uncomfortable.

This was my first case, so I went to my books, where I got very little comfort.

Rotch, quoting Monnier, said the cases not operated upon show a mortality of 80 per cent. The mortality percentage in the cases operated on is about 47.7 per cent.

Holt said: "After a positive diagnosis has been made the question of operation must be considered. It is held by many that operation is absolutely contra-indicated on account of its great attendant dangers, and as most cases recover without it. General experience, however, is opposed to this view. If careful and intelligent treatment produces no improvement, and vomiting continues until life is threatened, surgery holds out some hope of relief, though a slender one. Cases apparently hopeless have been rescued by operation. The greatest judgment is necessary not to continue the expectant treatment too long, and thus allow the child to become so wasted and exhausted that operation is inadmissible. About *one-fourth of the cases operated* on thus far have recovered."

Kerley said: "The only treatment, in the great majority of instances, is operation, with the outlook not promising."

Then I turned to recent medical literature and found the following comforting abstract in the *Jour. A. M. A.* of Jan. 15, 1910:

"Bendix: 'Treatment of spasm and stenosis of the pylorus in infants.'—Bendix regards these affections as pertaining exclusively to the domain of the internist, with breast milk as the main reliance. After a day on which nothing but water is allowed he lets the infant nurse at will; but if vomiting is very frequent and copious he restricts the amount and increases the number of feedings. From *six to eight weeks may pass before distinct improvement becomes evident, and the physician must be firm and not let himself be dissuaded from breast-milk feeding,* supplementing the child's nursing possibly by rectal enemas of breast milk, from 50 to 150 gm., several times a day. He lays great stress further on supplying fluids freely to the child to prevent water starvation. He does not approve of lavage of the stomach except possibly once at the beginning of treatment; it is liable to induce severe collapse. Moist heat to the stomach region, especially before

meals, frequent warm baths, and small doses of opium and valerian or an alkali are the main reliance. *He has never had to call in a surgeon, finding that a turn for the better occurred invariably by the end of the fifth or sixth week.* The first sign of improvement is when the child ceases to lose weight."

Knowing the excellent standing of Bendix as a pediatrist of large experience, I decided to take his advice and not consider surgery.

A minute hot-water bag was kept over the stomach.

A dose of codeia was given 10 minutes before feeding.

The feedings were small and close together.

Breast milk was used principally, but at the solicitation of the mother malted milk and condensed milk were tried, only to be discarded.

The introduction of fluid by the Murphy method was impossible. The attempt only showed what a wriggling thing even an unusually passive baby is.

Of course I am not going to draw too big a conclusion from one case. So far as it goes, however, it confirms rather than opposes Dr. Bendix's assertion that "Spasm and stenosis of the pylorus in infants pertains exclusively to the domain of the internist."

Correspondence.

Editor the Maryland Medical Journal,
Professional Building, Baltimore, Md.

Dear Sir—Will you be kind enough to insert the following notice in an early issue of your JOURNAL?

"My statement appearing on page 220 of this JOURNAL (September, 1913), that 'infection has occurred at least twice,' was based upon a report which on further investigation appears to be without foundation." (Signed) CHAS. C. W. JUDD

Book Reviews.

ELECTRICITY IN DISEASES OF THE EYE, EAR, NOSE AND THROAT. With illustrations. By W. Franklin Coleman, M.D., M.R.C.S., England; Ex-President of and Professor of Ophthalmology in the Post-Graduate Medical School, Chicago; Ex-President of the Ophthalmological Society of Chicago; Professor of Ophthalmology in the Illinois School of Electro-Therapeutics, Chicago, etc. The Courier-Herald Press. 1912. Cloth, $5 net.

This book is indeed welcome, as it goes thoroughly into every aspect of electricity as applied to diseases of the eye, ear, nose and throat. Many practitioners have been using electricity in a harum-scarum sort of a way, but without an exact idea as to what sort of a current to use, and how. It is this aspect of the book that par-

ticularly attracts, us, the writer not only advising the use of this or that form of electricity, but thoroughly describing how the form used acts. The volume encompasses the physics of electricity, the therapeutic use of electricity and the technic of its application, electricity in diseases of the eye, ear, nose and throat. Undoubtedly electricity is destined to play an important part in the cure of disease, but to accomplish the most good it must be used intelligently. Throughout the volume one is impressed with the absolute mastery of the author over his subject as illustrated by the numerous cases reported, the exact technic employed and the good results obtained. To one who is a believer in the efficacy of this agent the present volume, owing to the paucity of literature on medical electricity, is indeed a gratifying addition to the literature, especially so as it is so complete and withal personal. Some of the results obtained by the writer are certainly remarkable, but no less so than those obtained by other devotees to electricity. As the administration of electricity during the past few years has taken so many forms, all of which are treated tersely and plainly in the present volume, should make the book sought after not only by the specialist in diseases of the eye, ear, nose and throat, but also general practitioner.

Anoci-Association. By George W. Crile, M.D., Professor of Surgery, School of Medicine, Western Reserve University; Visiting Surgeon to the Lakeside Hospital, Cleveland; and William E. Lower, M.D., Associate Professor of Genito-Urinary Surgery, School of Medicine, Western Reserve University; Associate Surgeon to the Lakeside Hospital, Cleveland. Edited by Amy F. Rowland. Illustrated. Philadelphia and London: W. B. Sanders Company. Baltimore: The Medical Standard Book Co. Cloth, $3 net. 1914.

This is one of the most important monographs which have recently appeared. In it are embodied the investigations of Dr. Crile on the harmful influences arising during operation and the methods of their combattal. For many years Dr. Crile has been endeavoring to solve the operative technic with the least amount of shock to the patient. After trying one agent after another he finally discovered that nervous traumata were carried to the central nervous system during operation, which traumata, if of sufficient intensity, would produce shock. In order to short-circuit these insults he, amongst other means, injects cocaine into the skin befor incising, also the large nerves before cutting them. He states the ideal treatment for surgical shock is the direct transfusion of blood. His conclusions are based entirely on the kinetic theory of shock, namely, an insult to the body is repulsed by the automatic discharge of nervous energy either through ontogenetic or phylogenetic association. The monograph is an elaboration of this theory as applied to shock, with experimental and clinical experiences adduced as proof. According to this theory, all forms of shock

are caused by overstimulation and consequent exhaustion; that the cells of the brain, the suprarenals and liver show physical changes corresponding to each change in the clinical cycle of shock; that each shock-producing agency causes in the cells of the brain a hyperchromatic stage, followed by a hypochromatic stage. The organs of the body especially involved in shock are certain organs whose function is that of converting latent energy into kinetic energy in response to adaptive stimulation. These organs are the brain, thyroid, suprarenals, liver and muscles. In response to environmental stimuli of any sort these organs convert latent energy into motion or into heat. He illustrates by picture the changes in the brain cells which ensue as a result of shock, no matter what the agency, insomnia, over-drug stimulation, trauma, or what not. The book is certainly a testimonial to quiet, persistent, patient, scientific investigation, and the proof adduced certainly is strong enough to substantiate the author's claims.

THE TRAUMATIC NEUROSIS. (*The American Journal of The Medical Sciences, October*, 1914.) By Tom A. Williams, M.B., C.M., Edin., Washington, D. C., Pres. Wash. Soc. Nerv. and Ment. Dis., Corres. Mem. Soc. De Neurol., Paris, etc.

Of this misnomer the cause is shown to be merely psychic, derived from a false notion of the patient which induces depressing emotions, which disturb both the bodily health and life relation. A clear illustration of the mechanism is that of the "conditioning" of the gastric reflex of dogs by psychological stimuli, whether these are pleasurable or painful. The removal of the extraneous suggestion would remedy the neurosis but for the fact that memory maintains its action. So that the mental content must be modified at its foundation, and this requires considerable analysis of the patient's trends. Hence the complete failure of such naive procedures as reassurance and suggestion.

Lawsuits and malingering, so often interwoven with these cases, have created misunderstandings. But indemnity is not necessarily curative even of the malingerer. A case which lasted seven years after receiving heavy damages is reported.

In the complicated case, proper psychological reconstruction, made possible by clear analysis, inevitably cures, as the mechanism of neurotic disturbances after accidents differs in no way from that we find when there has been no accident at all. Furthermore, its nature is not of a complexity beyond the understanding of a layman, so that its principles can readily be grasped when presented in court by an expert witness who really understands them.

THE PRACTICE OF SURGERY. By James Gregory Mumford, M.D., Lecturer on Surgery in Harvard University; Surgeon to the Clifton Springs (N. Y.) Hospital; Fellow of the American Surgical Association; Recently Visiting Surgeon to the Massachusetts General Hospital, etc. With 683 illustrations. Second edition, thoroughly revised. Philadelphia and London: W. P. Saunders Company. Baltimore: The Medical Standard Book Co. 1914. Cloth, $7 net.

The second edition of Mumford's Surgery is, if anything, more complete than its predecessor. One thing which struck us particularly is the frankness of statement. You may not agree with what the author says, but at the same time you are willing to concede that he is absolutely convinced that he is telling the truth. The illustrations are well selected, numerous and admirably adapted to the text. We were somewhat disappointed that there were no Roentgengrams illustrating the sections on fracture and dislocation. In our opinion, such illustrations would have increased the usefulness of the text. Taken all in all, it is one of the best general textbooks on surgery on the market, and one will not go wrong in purchasing it when contemplating the acquisition of a thoroughly reliable book on general surgical topics. Of course, covering such a wide field, some topics must of necessity be touched on lightly. However, the author has exhibited good judgment in amplifying those subjects whose importance demand more than passing notice and passing over with few words the subjects of lesser importance. It is thoroughly reliable, dependable and abreast of the times.

A TEXTBOOK OF MEDICAL DIAGNOSIS. By James M. Anders, M.D., Ph.D., LL.D.; Professor of the Theory and Practice of Medicine and of Clinical Medicine, Medico-Chirurgical College of Philadelphia; Officer De L'Instruction Publique, etc., etc., and L. Napoleon Boston, A.M., M.D., Professor of Physical Diagnosis, Medico-Chirurgical College; Physician to the Philadelphia General Hospital; Pathologist to the Frankfort Hospital. Second edition, thoroughly revised, with 500 illustrations, some of them in colors. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. Cloth, $6 net. 1914.

This well-known book of over a thousand pages of diagnostic methods is as complete as the most fastidious could demand. It is a model of its kind, the authors seemingly not having overlooked a single method of practical value used in the detection of diseases. By the additions and changes it is brought as nearly as possible for any textbook abreast of the times. Amongst the most important additions may be mentioned: Movements of the two halves of the chest, electro-cardiagrams, Rampell-Leed phenomena in scarlet fever, colloidal nitrogen of the urine, fatty emboli, the tick in trans-

mitting relapsing fever, succession sounds audible over the abdomen, cobra-venom reaction in syphilis, Macewen's sign and Brudzenski's sign of epidemic meningitis, sweating and its significance, albuminous sputum, respiratory movements in hiccough, etc. As a diagnostic guide there certainly is no single volume that better

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Infant Feeding. By Clifford G. Grulee, A.M., M.D., Assistant Professor of Pediatrics at Rush Medical College (in affiliation with the University of Chicago); Chief of Pediatric Staff, Cook County Hospital; Attending Pediatrician to Cook County, Provident, and St. Bernard's Hospitals, and to the Home for Destitute Crippled Children, Chicago; Associate Pediatrician to the Presbyterian Hospital, Chicago. Illustrated. Second edition, thoroughly revised. Philadelphia and London: W. B. Saunders Company. Baltimore: The Medical Standard Book Co. 1914. Cloth, $3 net.

As a scientific exposition of infant feeding this book is thoroughly abreast of the times. It enters into the fundamental principles of infants' nutrition, special points in the anatomy of the gastro-intestinal tract of the infant, physiology of the gastro-intestinal tract in the infant, the physiology and pathology of absorption and metabolism, the bacteriology of the gastro-intestinal canal, the human breast and breast milk, nutritional disturbances in the breast-fed infant, foods used in artificial feeding, nutritional disturbances of the artificially-fed infant, as well as a rather detailed account of feeding in such conditions as the nervous infant, rickets, infantile scurvy, eczema, etc. It was not until 1905, when a systematic effort was made by Czerny and Keller, that infant feeding was placed upon a rational basis. Since that time infant feeding has made great strides, until now it is a science in itself. When one stops to think that one-fourth of all deaths occur in the first year of life, and that of these about 60 per cent. are due to gastro-intestinal disturbances, one can only then realize that a proper understanding of infant feeding is a necessary part of the armamentarium of the general practitioner. It is the shoulders of the general practitioner which must bear the burden of starting the child out right, and if these individuals are not prepared to assume this obligation they are lacking in their equipment. Therefore, those who feel they are not properly prepared will find in this book a simple, but absolutely reliable, statement of the modern principles underlying infant feeding.

MARYLAND MEDICAL JOURNAL

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BALTIMORE, DECEMBER, 1914

ABDOMINAL OPERATIONS.

INTRA-ABDOMINAL affections have so engrossed the attention of the profession of late and so much new light has been thrown upon this branch of medicine by such pioneers as the Mayos, Sir Arbuthnot Lane, Mayo Robson, Sir Berkeley Moynihan and others that our ideas concerning certain abdominal maladies have been completely changed. Like in all closed cavities until very recently our opinions as to what was going on had to be made from symptoms alone. It was indeed wonderful the diagnostic accuracy acquired by some under such conditions. Today the X-ray enables us to reach fairly accurate conclusions as to what is happening within the abdominal cavity. However, so far, the greatest progress in abdominal diagnostics was made through the exploratory incision of the pioneer surgeons mentioned above. They each and every one taught the lesson that chronic indigestion meant more than dyspepsia, that it meant disease of the gall-bladder, appendix, or other organ. We are therefore fortunate to have a book from the pen of one of these pioneers, one who had indeed done much to advance our knowledge of abdominal maladies, one who subscribes to his own opinions and observations, not others. Now for the third time Sir Berkeley Moynihan, M.S. (London), F.R.C.S., has rewritten and revised his book, "Abdominal Operations," and presented it to the profession in two volumes. As previously, the book is simply written and well illus-

trated. But best of all, after reading one is struck with the personality of the author permeating every page. Whether you are reading about symptoms, diagnosis or treatment, you are immediately impressed with the personal element entering into the make-up of the book. Rarely is it one's good fortune these days to procure a book expounding the opinions of the author alone, so that when one does come across such a book one is prone to give it more than the ordinary prominence. The latest surgery of the stomach, gall-bladder, biliary passages, large and small bowels and other intra-peritoneal organs is fully discussed by the author and amplified by magnificent illustrations.

We are in thorough accord with the author's statement. "The surgical treatment of cancer of the stomach still leaves much to be desired. The medical treatment is now, as it always has been, absolutely hopeless, and still involves a mortality of 100 per cent. The crying need in cases of carcinoma, not only of the stomach, but of all other parts of the alimentary canal, is for earlier diagnosis, and the chance of earlier surgical treatment. Amongst the notable achievements of surgery in recent years, chiefly as the result of the work in the Mayo clinic, is the proof that in a large proportion of cases the onset of cancer in the stomach is not a new and unaccountable thing, but is, on the contrary, a tardy development upon an earlier condition which for years has clamored for recognition."

He further states: "I am, of course, well aware that all cases of cancer of the stomach, unhappily, do not come to the surgeon. No one but the surgeon can do any good to a patient so afflicted. Yet there is a strange timidity of approach to the surgeon which is unaccountable, and far too often the favorable period in the history of the case is allowed to slip away before any recognition of real conditions is attempted." These few extracts admirably exemplify the character of the book. And, as here, throughout the author manifests a calm, judicial spirit in disposing of mooted questions.

Medical Items.

Dr. Herbert D. Taylor, who was graduated from Johns Hopkins Medical School in June, has been appointed professor of bacteriology and pathology, Wake Forest, North Carolina.

Dr. Taylor is a Baltimorean and a graduate of the class of 1910, St. John's College, Annapolis. For a time he was a member of the city staff of *The Sun*. Prior to going to Wake Forest he was engaged in dispensary work at Johns Hopkins Hospital.

At the meeting of the Baltimore City Medical Society, held at 1211 Cathedral street, Baltimore, Wednesday, October 21, 1914, interesting addresses were made by Drs. Hiram Woods, Lee Cohen, Alexander D. McConachie and H. O. Reik, all of Baltimore.

Dr. Eberle G. Welch and family, who have been spending some time at Atlantic City, where they were registered at the Chalfonte Hotel, have returned to their home.

A number of out-of-town physicians attended the sixth annual meeting of the American Association of Clinical Research, which was held in Baltimore, November 5, 6 and 7. Clinics were held at the Maryland General Hospital, the Biedler-Sellman Sanatorium (High Point), Dr. Howard A. Kelly's Sanatorium and the Hebrew Hospital. The sessions were held at Loyola College Hall. Mayor Preston welcomed the delegates to Baltimore at the first session, November 5.

Mrs. Ruth Briscoe has been appointed librarian of the medical department of the University of Maryland, Baltimore. The library contains more than 11,000 volumes.

At the twenty-fifth anniversary of the Johns Hopkins Medical School, tablets set in the walls of the hospital were dedicated. One of these tablets was in memory of the late Dr. John Hewetson, who was assistant resident physician at the hospital from 1890 to 1894. Another in the lobby of the main hospital building was in memory of the late Dr. Daniel C. Gilman, first president of the university; another to Dr. James W. Lazear of yellow-fever fame, and still another to Dr. Rupert Norton, who died only recently while assistant superintendent of the institution.

At the annual meeting of the University of Maryland Medical Society, held in the hospital amphitheater on the evening of October 20, Dr. Albert H. Carroll was re-elected president and Dr. J. Howard Maldeis, secretary, for the ensuing year. Interesting addresses were made by Drs. Randolph Winslow and Frank Martin.

The semi-annual meeting of the Medico-Chirurgical Faculty of Maryland was held October 28 and 29 at Upper Marlboro, Prince George's county, Md. Addresses were made by Dr. Randolph Winslow, president of the faculty, and Dr. Henry B. McDonnell, president of the Prince George's County Medical Society. A tablet was erected to Dr. William Beans, one of the founders and organizers of the faculty, whose death occurred in 1828. Public meetings and a health exhibit were held under the auspices of the public instruction committee of the faculty during the meeting.

Dr. Howard A. Kelly of Baltimore visited Lexington, Ky., October 22, and delivered an address on "Social Hygiene."

Dr. George H. Whipple, a member of the faculty of the Johns Hopkins Medical School, has been appointed a director of the George Williams Hooper Memorial Foundation for Medical Research in the University of California.

Dr. John F. Spearman, formerly of Baltimore, is on duty with the German forces near Strasburg.

Dr. Veader N. Leonard of Baltimore, who left on the first Red Cross expedition, is on duty at a 300-bed war hospital at Paignton, New Devonshire.

Dr. Henry Key is reported to be seriously ill at the Hotel Altamont, Baltimore, with double pneumonia.

Dr. Eleanor B. Wolf, Baltimore, has sailed for India, where she will be a member of the medical staff of the Guntur Hospital.

Jere Lord, the four-year-old son of Dr. J. Williams Lord of 1011 North Charles street, was recently cut on the head when the automobile, driven by his father in which he was riding, struck a westbound car of the Harford Avenue line. The injury was dressed at the Johns Hopkins Hospital.

The Travel Study Club of American Physicians, which made a successful study tour of Europe last year, has completed the plans for its 1915 study tour to the A. M. A. meeting in San Francisco, Honolulu, Japan, the Philip-

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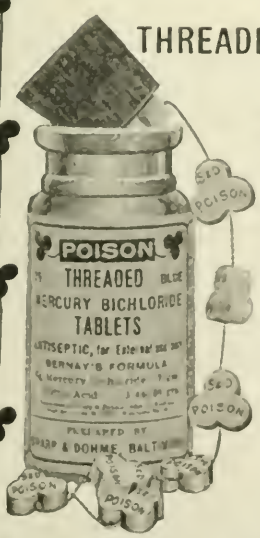

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pines, China, with optional return via Siberia and Europe or via Canada. This being the first party of American physicians ever visiting the Far East and the new possessions of the United States, a most cordial welcome can be expected by authorities and members of the medical profession. The Travel Study Club would like to make its enterprise as representative as possible, and asks all those interested to communicate with the secretary, Dr. Richard Kovacs, 236 East 69th street, New York.

The engagement has been announced of Walter Clark Haupt, M.D., Johns Hopkins Medical School, 1914, of Roland Park, to Miss Mary Alden Morgan of Chicago, Ill. Dr. Haupt is a member of the staff of the Butler Hospital, Providence, R. I. The wedding will take place in the spring.

Dr. J. Charles Macgill of Catonsville, while driving in his automobile a short while ago, collided with a Preston Street car. He escaped injury, but the machine was badly damaged.

BIRTHS.

To Roger Brooke, Jr., Baltimore Medical College, class of 1900, Major, M. C., U. S. A., and Mrs. Brooke, October 18, 1914, a son—Roger Brooke, 3d. Major Brooke is stationed at the Presidio, San Francisco, Cal.

MARRIAGES.

Lawrason Brown, M.D., Johns Hopkins Medical School, class of 1900, of Saranac Lake, N. Y., to Miss Martha Lewis Harris of Baltimore, at Midland, Va., October 8, 1914.

Edward John Kempf, M.D., assistant physician, Johns Hopkins Hospital, of Baltimore, Md., to Helen Dorothy Clarke, M.D., of Longwood, Boston, at Longwood, September 28, 1914.

Roland B. Whitridge, M.D., of Baltimore, Md., to Mrs. Katharine Whiting Wallauer of Oxford House, Rye, New York, at Rye, November 18, 1914. After a Southern wedding journey Dr. Whitridge and his bride will occupy the residence 1208 St. Paul street. Dr. Whitridge is a son of the late Dr. Joshua B. Whitridge of Charleston, S. C.

W. Edward Gorman, M.D., Atlantic Medical College, Baltimore, class of 1909, of Springfield, Mass., to Miss Julia A. Whitmore of Wilmington, Del., at New York, October 24, 1914. Both Dr. and Mrs. Gorman are well known in Baltimore.

Ernest Howard Gaither, M.D., Baltimore Medical College, class of 1905, of the Latrobe Apartments, to Miss Elsie C. Langrall, both of Baltimore, Md., at Baltimore, November 4, 1914. Dr. Gaither is assistant to Dr. Thomas R. Brown at the Johns Hopkins Hospital.

Herbert C. Blake, M.D., Baltimore Medical College, class of 1905, of Baltimore, Md., to Miss Helen Niely of Catonsville, Md., at Catonsville, November 14, 1914. Dr. and Mrs. Blake will reside at 1014 West Lafayette avenue.

DEATHS.

S. Butler Grimes, M.D., University of Maryland Medical School, '97, of 101 Longwood road, Roland Park, Md., died suddenly at the home of his father in Baltimore, October 25, 1914, aged 39 years.

Ernest J. Waddey, M.D., University of Maryland Medical School, '91, of Waterloo, Iowa, a Fellow of the American Medical Association, died in St. Francis' Hospital, Waterloo, October 14, 1914, from organic nervous disease, aged 47 years.

John H. Grimes, M.D., University of Maryland Medical School, '68, of 2100 Maryland avenue, died of uraemic poisoning at the Enoch Pratt Hospital, November 7, 1914, aged 73 years. Dr. Grimes was stricken with paralysis three years ago and had been failing ever since.

William James Lumsden, M.D., University of Maryland Medical School, '69, a Fellow of the American Medical Association; for more than 40 years a practitioner of Elizabeth City, N. C.; one of the most beloved physicians of North Carolina, died at his home, October 14, 1914, from cerebral hemorrhage, aged 68 years.

Josiah T. Payne, M.D., University of Maryland Medical School, '68, a Confederate veteran and health officer of the Tenth District of Baltimore County, Md., died at his home in Sunny Brook, Md., October 2, 1914, from cerebral hemorrhage, aged 75 years.

Collier D. East, M.D., College of Physicians and Surgeons, '76, a member of the South Carolina Medical Association, of Goldville, S. C., died at the home of his sister in Clinton, S. C, September 20, 1914, from heart disease, aged 62 years.

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PRINCIPLES OF CRIMINAL ANTHROPOLOGY.

By Arthur MacDonald, Washington, D. C.,

Honorary President of the Third International Congress of Criminal Anthropology of Europe.

Criminal anthropology is a recent line of research. It includes the study of man mentally, morally and physically, and necessarily depends on the results of many sciences. It is therefore distinctively *synthetic* in character. Criminal anthropology affords more opportunities for persons of ability to carry out the highest ideals than any other branch of inquiry.

The following are some of the principles of criminal anthropology, or what might be called its platform:

1. Degrees of criminality should be estimated according to detriment to the community. From this point of view, international crime, or war, is by far the greatest of all crimes.

2. History is mainly history of the abnormal, especially war, and one of the objects of criminal anthropology is to lessen and prevent war. Montaigne says: "It is more barbarous to kill a live man than to roast and eat a dead one."

3. The greatest of all studies is man, which is based upon the individual, the unit of the social organism.

4. If the study of civilized man is to become a science, it must depend upon investigation of large numbers of individuals, and the method should be the same for all classes, if we are to distinguish between the normal and abnormal.

5. The best method of study for criminal anthropology is that of the laboratory in connection with sociological data.

6. The thorough investigation of *one* human being with the means at the disposal of science would make a volume.

7. All facts about human beings are important from the scientific point of view, whether those facts be immediately available or not.

8. All that is diseased is abnormal, but not all that is abnormal is diseased; thus a hand with six fingers is abnormal, but not necessarily diseased.

9. We must study the normal to comprehend the abnormal, for

10. When the normal acts in an unsuitable way, or at the wrong time or place, it may become abnormal. The fundamental conception of the abnormal is *excess* of the normal; but

11. The difference in degree between the normal and abnormal can be so great as to result in a difference of kind; just as when two fluids reach a certain amount, a precipitate is formed which is very different from the ingredients from which it was deposited.

12. Abnormal man may be abnormal in the right direction, as genius man, talented man or statesman; or in the wrong direction, as criminal, pauper or defective man. It is all *man*, and the study of these different classes might be called the anthropology of the living as distinguished from prehistoric anthropology.

13. Of all forms of abnormal humanity, crime is nearest the normal; the study of criminals, therefore, is mainly the study of normal men, and knowledge thus gained may be generally applicable to the community as a whole. Therefore,

14. The prison and reformatory can serve as a humanitarian laboratory for the benefit of society. As the surroundings of the inmates are similar, conditions for scientific research are favorable.

OPEN LETTER

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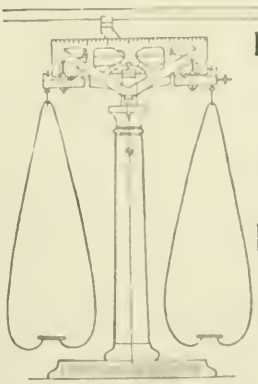

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15. As in machinery we first repair the parts out of order, so in society we first study the criminal, pauper, insane, feeble-minded and other defectives, all of whom constitute about 1 per cent. of the community. But

16. Why should we allow 1 per cent. of society to cause so much trouble and expense to the remaining 99 per cent., crime alone costing more than one-half billion dollars annually? It is mainly because of neglecting the young, where study of man should begin. For

17. There is little hope of making the world better if we do not seek the cause of social evils at their foundation.

18. No evil can be *permanently* lessened without first finding its cause. There is probably no *one* cause of anything, but a chain of causes.

19. Drunkenness is not only one of the main causes of crime, but one of the greatest enemies of humanity, because it brings suffering upon so many innocent people.

20. We cannot be tempted to do wrong unless there is something in us to be tempted; that something is a part of ourselves as distinguished from our environment; therefore,

21. The comprehensive study of man requires investigation of both individual and his surroundings, for the environment may be abnormal rather than the man.

22. Cranks or mattoids who attempt the lives of prominent persons are very important solely on account of the enormous injury they can do to society. They therefore should be studied most thoroughly.

23. Just as the physician studies his patient in order to treat him properly, so one should study the criminal.

24. The exhaustive investigation of a single criminal illustrates just how and by what steps both environment and inward nature lead to criminal acts.

25. Criminals, paupers and other defectives are social bacilli which require as thorough scientific investigation as the bacilli of physical disease.

26. No one should be held responsible for the first fifteen years of life, nor is anyone accountable for the tendencies inherited from ancestors. As the die is usually cast before adult life arrives, responsibility is most difficult to determine, and is often a minimum quantity. Therefore,

27. In judging human beings we should emphasize their excellencies rather than defects. As has been said, to know all is to forgive all; yet

28. Every person dangerous to property or life, whether insane, criminal or defective, should be confined, but not necessarily punished.

29. The determinate sentence permits prisoners to be released who are morally certain to return to crime. The indeterminate sentence affords the prisoner an opportunity to reform without exposing society to unnecessary danger; but

30. Society has no right to permit prisoners to be released who will probably return to crime; for

31. Where it is a question between justice to the individual or justice to the community, the community should have the benefit of the doubt.

32. The prison should be a reformatory and the reformatory a school; the object of both should be to teach good mental, moral

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PROFESSIONAL BUILDING

and physical habits; both should be distinctly *educational.* There should be a minimum temptation to do wrong and a maximum encouragement to do right.

33. Institutions for reforming human beings should have the conditions as similar as possible to surroundings outside, so that when inmates are released they may adapt themselves more easily to society and not become misfits.

34. Everyone has the right to a proper bringing up; and

35. The time has come when we should study a child with as much exactness as we investigate the chemical elements in a stone or measure the mountains on the moon.

36. One purpose of criminal anthropology is, through knowledge gained by scientific study, to protect the weak, especially the young, *in advance,* before they have become tainted and fallen; not locking the barn door after the horse is stolen.

37. The treatment of young criminals should be the prototype for treatment of adults, and procedures against them should have as little publicity as possible.

38. Publication in newspapers of criminal details is an evil to society on account of the power of imitation. In addition it makes the criminal proud of his record, develops the morbid curiosity of the people, and it is especially the weak who are affected.

39. Place confidence in the so-called bad boy, awaken his ambition and teach him to do right for right's sake.

40. Put the criminal upon his honor. A criminal once said: "If they will not believe me when I tell the truth, I might as well tell lies."

41. Nothing will hinder development of the young more than the prospect of having plenty of money and no necessity to work. Idleness often leads to crime.

42. It is more important to know what is good than what is true; for

43. Increase in intellectual development is not necessarily connected with increase of morality, and education which trains the mind at the expense of the will is a questionable education.

44. The longer we live, the more we appreciate the average honest man, as compared with the dishonest talented man.

45. To any observer of life, the impracticability of pessimism and the advantages of optimism are evident. It has also been estimated that

46. Most of our thoughts, feelings and acts are indifferent; but of those remaining, three-fourths are pleasurable and one-fourth painful, indicating more pleasure than pain in the world.

47. Act as thou wouldst act, if all the consequences of thy act could be realized at the moment thou actest.

ANESTHESIA AMONG THE INDIANS.

The anterior history of ancient anesthetic agents and methods is, with some difference, similar to the works of other authors and writers on this topic, but the following research of the "Anesthesia among the Indians" is original of Dr. J. M. G. Kukay, as will be shown in this course.

It is very difficult to write on any subject of remote times without a manuscript or some other information to give some light on the writer's investigation excepting mummies, trephined skulls and the revelation of some far descendants of the Incas Indians.

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If it is not possible to know the date and name of the first discoverer of anesthesia in civilized Europe, is it possible to know this in the savage region of America prior to Columbian time? The following brief history is the way taken by the writer in his research:

In the year 1904 I have a few pages of this work, and anything in regard to this subject was a point of investigation and study for me. When visiting our American Museum of Natural History of New York my attention was called to the collection of Indian mummies, buried with a sack of coca leaves, and the trephined skulls, brought by Mr. E. G. Squier from the burials of the Incas Indians at Chiara Valley, Peru.

My first step in this research was a visit to Peru, one year after. Once in the Valley of Yucay, I began to ask of the natives if they knew the use of coca among the Indians, but no one knew anything about it. Finally I got the address of an Indian's descendant, by name Señor Juan, who lived several miles away, and I went to his camp, accompanied by a native. Señor Juan was about 90 years of age. He don't know it. After I told him the object of my visit (the writer is familiar with the Spanish language), he said: "We don't use books or any writing, but we keep all the records in the 'Quipu,' in which by the color of the cord, length, number of knots, and kind of it, etc., we record the important incidents, and by memory the non-important ones."

Can you tell me why your forefathers were buried with coca leaves? I asked.

"Certainly," he answered. "Before the Spaniards came we were more happy and rich, and when a 'Cacique' (Indian chief) or some member of his family dies, the relatives put with many other things the holly leaves."

What other use have they for these leaves?

"Oh, many," he said. "We use it even today as a tonic, to relieve pain, and chew it as you do with tobacco."

Can you explain the reason of the perforation of the skull?

"Of course," he answered. "This was done to the son or son-in-law of the dead 'Cacique,' and was a religious ceremony. If the son lived after the operation, he became cacique, but the most died after cutting the square hole in his head."

Do they use any coca leaves in the operation? I asked.

"Yes, plenty. The 'curanderos' (Indian physician) mixed in one concave stone a large quantity of leaves and water, and with another stone like a pastle trituriated them very fine to the consistency of a syrup. Then they gave slowly to drink until they do not move, and the curanderos start the operation, which takes sometimes a whole day, and all the time during the operation the men, women and children pray with their prayer-sticks."

What do they do in case the man feels pain?

"Well, they give more stuff to drink."

Did they die before the operation was over on account of the syrup?

"Very few. The curanderos have very much experience in handling the coca, and they know the danger by the color of the skin."

Have you seen any of such operations? I asked.

"No. They were used when the Incas domained this country, or on times that no Christian inhabited here."

How do you know all those customs among your people?

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"Easy; some by memory from my fathers, grandfathers, etc., and others by old 'Quipus.'"

After all this caudal of information, the writer went to Surco, Peru. In this place he compiled more information on the use of coca leaves; among the different uses was that they gave to eat coca leaves to the Indian women in labor time. But nobody gave so complete and important information as Señor Juan.

By this revelation and the evidence from the museum, the writer was completely convinced that coca leaves were used to produce narcosis and anesthesia by the Incas Indians of Peru, in performing surgical operations by means of knives made from copper, bronze and stone.

No one that knows the works of Dr. von Tschudi, Mr. E. G. Squier and the writer's research will doubt this statement.

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"What is this wonder-working thing, this twilight sleep?" asks the *Ladies' World;* and it answers: "Nothing in the world but the skillful use of anesthetics to produce that very fine balance between the states of consciousness and unconsciousness where the patient cannot recollect immediate sensations, such as pain, yet is in full possession of her muscular power and her will to help. These are the ideal conditions for a safe, normal, painless birth. They have been obtained by the great physicians of Germany. They can be obtained by the equally skillful doctors of America. They can be obtained in your town and mine, in the childless home of the terrified young husband, in your home and your daughter's home—everywhere."

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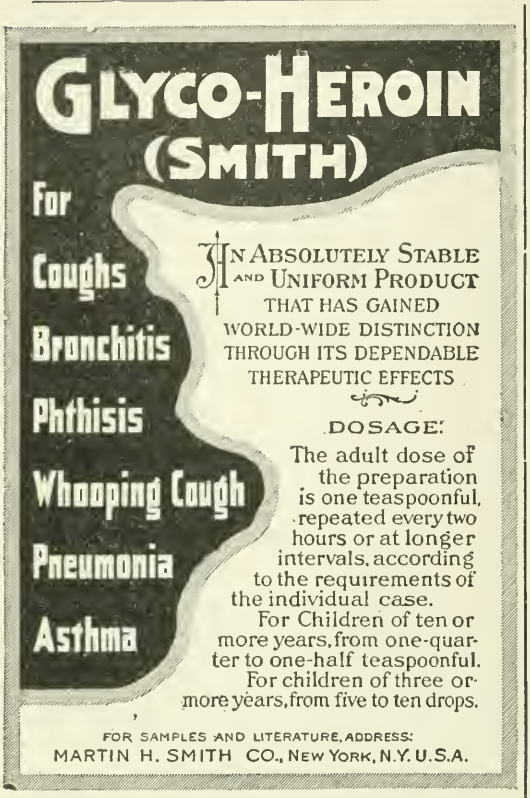
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¶ Stone, Brick and Steel Buildings, with every modern comfort. Two Elevators and five Sun Parlors.

¶ Convalescents can have specially prepared diets and other helps, and be under control and advice of home physician through our resident.

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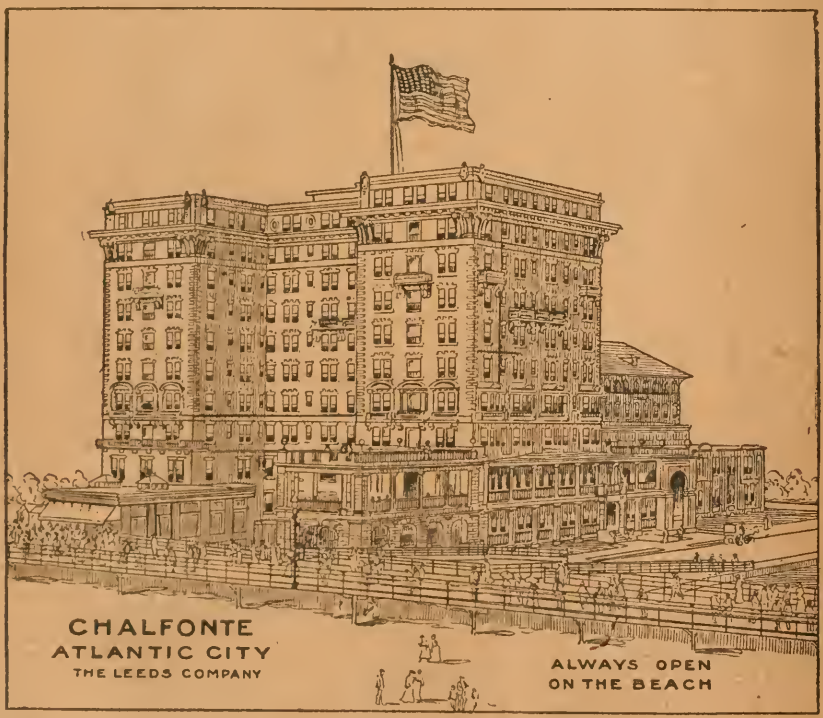
F. L. YOUNG, General Manager



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